

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-22

CERTIFICATE OF DEATH

Dr. Wells
09321

Reg. Dist. No. 302 305

1. PLACE OF DEATH:

County Washington
City or town Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
Breathedsville, Md.
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Breathedsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war no

3. (a) FULL NAME

Olin Ray Andrews

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 8. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Ava Naomi Andrews
7. Birth date of deceased (mo., day, yr.) May 11, 1888
6. (c) It alive, give age 50 years
8. AGE: Year 58 Months 4 Days 12 It less than one day
hrs. min.

9. Birthplace Hurlock, Dorchester, Md.
(Town, county, and state)
10. Usual occupation Farm Mgr
11. Industry or business Md. State Penal Farm
12. Name J. B. Andrews
13. Birthplace Hurlock, Md.
14. Maiden name Mary Todd
15. Birthplace Hurlock, Md.

16. Informant Mrs. Ava Naomi Andrews
Address Breathedsville, Md.
17. Burial Date thereon Sept. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Kryder's Cemetery
Location Westminister, Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown, Md.

19. Sept. 23, 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1946 at 2P
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h. alive on 19
Immediate cause of death Open fracture of cervical vertebra
Due to Fractured ribs (rt)
Due to Fractured humerus
Other conditions lyt-
(Include pregnancy within 3 months of death)

Major findings of operations No Date of op. No
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date Sept. 23/46
Where did injury occur? State Penal Farm Wash, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) B&O RR
Means of injury Auto struck by train Injured at work? No
23. SIGNATURE H. P. Wells M. D. or other WASH. CO. MD.
Address Hagerstown, Md. Date signed Sept. 23/46

Important physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 27 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

09322

★ Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
County.....
City or town..... near Clearfoss md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hagerstown RD #4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... md County..... Washington
City or town..... near Clearfoss md
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Hagerstown RD #4
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

SARAH E. AUGHINBAUGH

3. (b) Social Security Number

none

4. Sex..... 7
5. Color or race..... white
6. (a) Single, married, widowed, or divorced..... married
B. (b) Name of husband or wife..... John W. Aughinbaugh
B. (c) If alive, give age..... 74 years
7. Birth date of deceased (mo., day, yr.)..... May 24 1873

8. AGE: Years..... 73 Months..... 3 Days..... 7 If less than one day..... hrs..... min.....

9. Birthplace..... Franklin Co Pa
(Town, county, and state)

10. Usual occupation..... Home wife

11. Industry or business..... Home

12. Name..... John Gains

13. Birthplace..... Franklin Co. Pa

14. Maiden name..... Mary B. Graham

15. Birthplace..... Franklin Co Pa

16. Informant..... John W. Aughinbaugh

Address..... Hagerstown RD #4

17. (Burial, cremation, or removal. Which?)..... 13 Date thereof..... Sept. 4/46
(month) (day) (year)

Cemetery or crematory..... Cedar Hill

Location..... Greencastle Pa

18. Funeral director..... J. E. Munnich

Address..... Greencastle Pa

19. 8-3-46 19-46 6-11-46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 1st 1946 at 8P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to Sept 1 1946 and that I last saw her alive on Sept 1 1946

Immediate cause of death..... myocardial infarction
chronic with deceleration

Due to..... arterio sclerosis

Due to..... with hypertension

Other conditions..... diabetes mellitus

DURATION

6 yrs.

5 yrs.

10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Autopsy results.....

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE..... William A. Suenon M. D. or other

Address..... Greencastle Pa Date signed..... 3 Sept 46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 5 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Dr. LeVan

C9323

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Years
 Hospital, institution, or street address where death occurred:
Fahrney Memorial Home
 How long in hospital or institution? 4 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 238 South Mulberry St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

Mrs. Susan Catherine Ausherman

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife John D?6. (c) If alive, give age - years7. Birth date of February 20 1864
 (mo., day, yr.)8. AGE: Years Months Days It less than one day
82 6 15 hrs. min.9. Birthplace Myersville Fred. Co. Md.
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business --FATHER 12. Name John D. Delauder13. Birthplace Myersville Md.MOTHER 14. Maiden name Rebecca Renner15. Birthplace Myersville Md.16. Informant Mrs. Herman HarbaughAddress Hagerstown Md.17. Burial Date thereof 9/7/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept. 7, 1946 John N. Bask
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946 at 6.15 M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Sept 1 1946 to Sept 5 1946
 and that I last saw her alive on Sept 5 1946Immediate cause of death Cerebral HemorrhageDue to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. LeVan M.D.Address Boonsboro Date signed 9/6/46

RECEIVED
SEP 12 1946
BUREAU OF
A & OVER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Bell

CERTIFICATE OF DEATH

Reg. Dist. No. 224302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
45 Elizabeth St.
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 45 Elizabeth St.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

John Tilman Barber

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Emma C.

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1875 6. (c) If alive, give age 69 years

8. AGE: Years 70 Months 7 Days 25 If less than one day hrs. min.

9. Birthplace near Wilson, Wash. Cty., Md.
(Town, county, and state)

10. Usual occupation Painter
Own Business

11. Industry or business

12. Name John H. Barber

13. Birthplace Funkstown, Md.

14. Maiden name Mary C. Hose

15. Birthplace Wilson Dist., Md.

16. Informant Mrs. Emma C. Barber

Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 14, 1946
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Sept. 14, 46 (Date rec'd by registrar) Chas. Dawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1946 at 9:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5, 1946 to Sept. 10, 1946 and that I last saw him alive on September 10, 1946

Immediate cause of death

Cerebral hemorrhage DURATION 6 months

Due to

Due to

Other conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Bell M. D. or other

Address Hagerstown, Md. Date signed 9/13/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 17 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Dr. Young.

Reg. Dist. No. 09325 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Wash. County Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Illinois County Cook
City or town Chicago
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6225 Blackstone Ave.
(If rural, give LOCATION)
2. (a) If veteran, name war none ✓

3. (a) FULL NAME

Benjamin F. Bausman

3. (b) Social Security Number

334-14-5982

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife none

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

8. AGE: Years 79 Months 3 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Cty., Md.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Department Store

12. Name Jacob Bausman

13. Birthplace Hagerstown, Md.

14. Maiden name Barbara Kauffman

15. Birthplace Hagerstown, Md.

16. Informant Mrs. J. M. Tombaugh

Address Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 9, 1946
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Sept 7 1946 Registrar Blair H. Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1946 at 3:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/24/46 to 9/7/46 and that I last saw him alive on 9/7/46

Immediate cause of death _____ DURATION _____

Cerebral Hemorrhage pro

Due to _____

Due to _____

Other conditions _____

Myocardial Infarction (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Blair H. Bowers M. D. or other _____

Address Hagerstown, Md. Date signed 9/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 10 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 0932200

1. PLACE OF DEATH:

County Washington
City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs.
Hospital, institution, or street address where death occurred:
Sharpsburg
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Edgar Bender Bender

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of ~~husband~~ or wife Agnes May Still Bender

7. Birth date of deceased (mo., day, yr.) April 23 1880 6. (c) If alive, give age 62 years

8. AGE: Years 66 Months 5 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Sharpsburg Md
(Town, county, and state)

10. Usual occupation labor

11. Industry or business National Cemetery Sharpsburg

12. Name Benjamin Bender

13. Birthplace Sharpsburg Md

14. Maiden name Elizabeth Highberger

15. Birthplace Sharpsburg Md

16. Informant Mrs. Agnes May Bender

Address Sharpsburg Md

17. Burial Date thereof Oct 2 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt View Cemetery

Location Sharpsburg Md

18. Funeral director Edith V. Leaf

Address Williamstown Md

19. Oct 14 1946 Registrar Edith V. Leaf

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 29 1946 at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to Sep 29 1946 and that I last saw him alive on Sep 29 1946

Immediate cause of death Cardio Vascular Renal Disease DURATION 5 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. Wangers MD. M. D. or other _____

Address Shepherdstown, W. Va. Date signed Sep 30 1946

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

14-100-1
OCT 4 1916
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

C9327

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
No. 66 Broadway
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 830 N. Bentley St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Mellie Blickenstaff

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Elkane Blickenstaff
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September - 5 - 1868

8. AGE: Years 78 Months 0 Days 6 If less than one day _____ hrs. _____ min.

8. Birthplace Wolfville Fred. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Benjamin Shuff

13. Birthplace Fred. Co. Md.

14. Maiden name Sarah

15. Birthplace Fred. Co. Md.

16. Informant H. Ronald Blickenstaff

Address No. 66 Broadway, Hagerstown Md.

17. Burial, cremation, or removal. Which? Burial Date thereof Sept. 14, 1946
(month) (day) (year)

Cemetery or crematory Benevola Cemetery

Location Benevola Md.

18. Funeral director Wm. S. Best & Sons

Address Boonsboro Md.

19. Sept 13, 1946 Registrar Chas. Howard
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1946 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 1946 to Sept 11 1946 and that I last saw her alive on Sept 11 1946

Immediate cause of death Senile Hemiplegia
Due to _____
Due to _____

DURATION

1 Day

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. Beasley M.D.

Address Hagerstown, Md. Date signed Sept. 11/46

Dr. Jack Beasley

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 16 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163

CERTIFICATE OF DEATH

Reg. Dist. No.

09328

302

1. PLACE OF DEATH:

County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 739 Chestnut Street
(If rural, give LOCATION)

2. (a) If veteran, name war...

3. (a) FULL NAME

Grover Cleveland Boward

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife... Rose Boward

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1887

8. AGE: Years 58 Months 11 Days 29 If less than one day
...hra. ...min.9. Birthplace... Hagerstown-Wash. Md.
(Town, county, and state)

10. Usual occupation... Electric Welder

11. Industry or business

12. Name... Emanuel Boward

13. Birthplace... Wash. Co., Md.

14. Maiden name... Ellen Springer

15. Birthplace... Hagerstown, Md.

16. Informant... Mrs. Virginia Keyser

Address... 32 Fairground Ave- Hagerstown, Md.

17. Burial Date thereof... Sept. 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rose Hill Cemetery

Location... Hagerstown, Md.

18. Funeral director... Fred W. Kraiss

Address... Hagerstown, Md.

19. (Date rec'd by registrar) Sept 25, 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 22, 1946 10:31 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him... alive on

Immediate cause of death...

Multiple fractures of skull
Hemorrhage into brain

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Homicide Date of 9/22/46

Where did injury occur? Hagerstown Wash. Md.

Injured at home, farm, industry, public place (where?) S. W. Corner of McPherson & W. Frank-

Manner of injury Fight Injured at work? No

DEPUTY MEDICAL EXAM.

23. SIGNATURE... S. W. Corner of McPherson & W. Frank-
Address... Hagerstown, Md. Date signed 9/23/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 27 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

CERTIFICATE OF DEATH

09329

Reg. Dist. No. 386

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Helen Grace Smith Brown

3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Russell A Brown6. (c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.) March 26 1895

8. AGE:

Years

Months

Days

If less than one day

5158

.....hrs.

.....min.

9. Birthplace

Fairfield Penna
(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

Calvin Smith

13. Birthplace

Cascade Ind

MOTHER

14. Maiden name

Nancy Miller

15. Birthplace

Cascade Ind

16. Informant

Address

Russell A Brown
Cascade Ind

17. Burial

(Burial, cremation, or removal. Which)

Date thereof

9 7 1946
(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Near Cascade, Ind

18. Funeral director

Address

Walter H. Grove
Waynesboro Penna

19. Sept 5 1946

(Date rec'd by registrar)

Geo W. Ferguson
Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1946 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 1918 to Sept 4 1946and that I last saw him alive on 9-3-46

Immediate cause of death

Apoplexy -

DURATION

Due to

Due to

Other condition

Misadema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H C Bridgers

M. D. or other

Address

Blue Ridge Summit Pa

Date signed

9/5/46

RECEIVED

SEP 17 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

CERTIFICATE OF DEATH

Reg. Dist. No. 09330 302

1. PLACE OF DEATH:

County..... Washington County
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Michigan County..... Wayne
 City or town..... Detroit
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Penrod Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George William Butler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Minerva F Butler

7. Birth date of deceased (mo., day, yr.)

June 25, 1892

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

54

2

20

hrs.

min.

9. Birthplace

Detroit, Michigan
 (Town, county, and state)

10. Usual occupation

Emp. Miller-Seldon Elect. Co.

11. Industry or business

Detroit, Michigan

FATHER

12. Name

Emanul Butler

13. Birthplace

Nova Scotia

MOTHER

14. Maiden name

Charlotte

15. Birthplace

England

16. Informant

Robert Butler

Address Detroit, Michigan

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Sept. 20, 1946
 (month) (day) (year)Cemetery or crematory..... Roseland CemeteryLocation..... Detroit, Michigan

18. Funeral director

Fred W. Kraiss

Address..... Hagerstown, Md.

19. (Date rec'd by registrar)

Sept. 16, 1946
 Registrar Blair Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept/ 14 1946 at 5:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him..... alive on19.....

Immediate cause of death.....

DURATION

laceration of brain
Open fracture of left femur
Multiple fractures of ribs
hemorrhage & shock

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... as above Sept/14/46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of..... 9/14/46
 Where did injury occur?..... near Woodward Ave. - 5th St.
 (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Auto collision Injured at work?..... No

23. SIGNATURE

S. Robert & Wells
Hagerstown, Md. Date signed..... 9/16/46

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. - other

RECEIVED

SEP 18 1945

BUREAU V.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Sandy Mar - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
 How long in hospital or institution? 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Carroll
 City or town Westminster
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) none
 2.(a) If veteran, name war none

3. (a) FULL NAME

Harvey C. Caylor

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife Engel Caylor7. Birth date of deceased (mo., day, yr.) October - 30 - 1861

8. AGE: Years 84 Months 10 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Amos Caylor13. Birthplace Pipe Creek Md.14. Maiden name Rachel E. Smith15. Birthplace Westminster Md.16. Informant John BeardAddress Westminster Md.17. Burial Date thereof Sept 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pipe Creek CemeteryLocation Pipe Creek Md.18. Funeral director J. E. Myers Jr.Address Westminster Md.19. Sept - 8 - 1946 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1946 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946 to Sept 8 1946
 and that I last saw him alive on September 8 1946

Immediate cause of death ThaemiaDue to arterio sclerosis with deggangrene of both feetDue to Chronic myocarditis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. L. M. D.Address Boonsboro M. D. or other _____Date signed Sept 8, 46

DURATION

1 wk6 wks5 yrs.

RECEIVED

SEP 10 1946

RECEIVED

SEP 10 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09331

304

1. PLACE OF DEATH:

County.....Washington
City or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....Seven Days
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....Maryland County.....Washington
City or town.....Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(c) If veteran, name war.....

3. (a) FULL NAME

Richard Edward Coffman

3. (b) Social Security Number

NONE

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Single
6.(b) Name of husband or wife.....
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....November 2 1942
8. AGE: Years.....3 Months.....10 Days.....1 If less than one day..... hr. min.

9. Birthplace.....Uniontown Pa.
(Town, county, and state)
10. Usual occupation.....Infant
11. Industry or business.....

12. Name.....Clarence Coffman
13. Birthplace.....Alleganay Co.
14. Maiden name.....Gladys Hill
15. Birthplace.....Berkley Spring Wva

16. Informant.....Clarence Coffman
Address.....Hancock, Md.

17. Burial.....Burial Date thereof.....Sept. 6 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory.....Damascus
Location.....Fulton Co. Pa - Near Hancock, Md

18. Funeral director.....Snyder- Rowland
Address.....Hancock, Md.

19. 9-4-46 19.....9-4-46
(Date rec'd by registrar) Registrar.....J. A. Heller

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Sept 3-46 19..... at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3-46 19.....
and that I last saw him.....Sept 3-46 19.....

Immediate cause of death.....Crushed abdomen
Due to.....Fractured femur
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide.....Accident Date of.....9/3/46
Where did injury occur?.....Hancock Washington Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....Public Highway
Means of injury.....Run over by automobile Injured at work?.....No

23. SIGNATURE.....Edw. Heller M. D. or other.....Acting
Address.....Hopkinton Ind Date signed.....9/4/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MU

RECEIVED
SEP 6 1945
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

Reg. Dist. No. 0033303

1. PLACE OF DEATH

County Washington
 City or town Clear Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clear Spring Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Annie Amelia Coulton

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Charles Coulton

7. Birth date of deceased (mo., day, yr.)

May 26 1863

8. (c) If alive, give age _____ years

8. AGE:

83316

If less than one day

hrs. min.

9. Birthplace

Washington Co.
(Town, county, and state)

10. Usual occupation

Home Work

11. Industry or business

FATHER

12. Name

Rudolph Kreps

13. Birthplace

Washington Co.

MOTHER

14. Maiden name

Elizabeth Kuhn

15. Birthplace

Washington Co.

16. Informant

Charles Coulton

Address

Clear Spring

17. Burial

BuriedDate thereof Sept. 14 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Clear Spring

18. Funeral director

Snyder-Routland

Address

Clear Spring, Md

19. Date rec'd by registrar

Sept 13 1946

19. 46

Jeffrey W. Mueser
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 12 1946 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 6 1946 to Sept 12 1946
and that I last saw him alive on Sept 11 1946

Immediate cause of death

Fracture of right hip - Due to accidental fall in her home

DURATION

6 days

Due to

Due to

Other conditions

Cardio Renal Collapse
(Include pregnancy within 3 months of death)3 days

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

David R. Brewer M.D.
Address Clear Spring, Md Date signed 9/12/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 16 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-8)

CERTIFICATE OF DEATH

09334

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town near Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1.2 years
 Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 1
 How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town near Boonsboro Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 1
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

Graham Albert Culbert

3. (b) Social Security Number

372-14-4371

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Helen Culbert
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 22 - 1908
 8. AGE: Years 38 Months 3 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Michigan
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Milk Route operator
 12. Name Knesly Culbert
 13. Birthplace Standish Michigan
 14. Maiden name Addie Grimshaw
 15. Birthplace Mt. Forest Ontario

16. Informant Knesly Culbert Jr.
 Address Boonsboro Md. R. 1
 17. Burial Date thereof Sept 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Forest Lawn Cemetery
 Location Saginaw Michigan
Am. S. East Mort.
 18. Funeral director Boonsboro Md.
 Address Boonsboro Md.
 19. Sept. 20 19 46 John H. East
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 19 46 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19_____, to _____ 19_____,
 and that I last saw him _____ alive on _____ 19_____.
 Immediate cause of death _____

CAUSE TO BE SUPPLIED LATER	DURATION
Due to <u>Acute strychnine poisoning</u>	
<u>Accidental</u>	
Due to _____	
Other conditions _____	
(Include pregnancy within 8 months of death)	

Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE A. Robert & Wells DEPUTY MEDICAL EXAM.
WASH. CO. MD.

Address Wagartown Md. Date signed 9/20/46

RECEIVED
SEP 24 1945
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: <i>Washington</i> County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <i>65 years</i> Hospital, institution, or street address where death occurred: <i>Washington County Home</i> How long in hospital or institution? <i>15 years</i>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <i>Maryland</i> County <i>Washington</i> City or town <i>Hagerstown</i> (If outside city or town limits, write RURAL and give nearest town) Street No. <i>Washington County Home</i> (If rural, give LOCATION) 2.(a) If veteran, name war.....		
3. (a) FULL NAME <i>Howard Dorsey</i>			3. (b) Social Security Number		
4. Sex <i>Male</i> 5. Color or race <i>Negro</i> 6.(a) Single, married, widowed, or divorced <i>Widower</i>			MEDICAL CERTIFICATION		
6.(b) Name of husband or wife <i>Carrie Dorsey</i>			20. DATE OF DEATH <i>Sept 18th</i> 19 <i>46</i> , at <i>6 P</i> M		
7. Birth date of deceased (mo., day, yr.) <i>June 19, 1881</i> 6.(c) If alive, give age years			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Sept 1st</i> 19 <i>46</i> to <i>Sept 18</i> 19 <i>46</i> and that I last saw him alive on <i>Sept 18</i> 19 <i>46</i>		
8. AGE: Years <i>65</i> Months <i>3</i> Days If less than one day hrs. min.			Immediate cause of death DURATION		
9. Birthplace <i>Hagerstown, Wash. Md.</i> (Town, county, and state)			<i>Carcinoma of Esophagus</i> <i>6 mo.</i>		
10. Usual occupation			Due to		
11. Industry or business			Due to		
12. Name <i>John T. Dorsey</i>			Other conditions		
13. Birthplace <i>Frederick, Md.</i>			(Include pregnancy within 3 months of death)		
14. Maiden name <i>Sarah Jane Davis</i>			Major findings of operations		
15. Birthplace <i>Hagerstown, Md</i>			Date of op.		
16. Informant <i>Mrs Maude Ford</i>			Autopsy results		
Address <i>406 N. Jonathan St.</i>			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
17. Burial <i>Burial</i> Date thereof <i>9/21/46</i> (Burial, cremation, or removal. Which?) (month) (day) (year)			22. VIOLENCE: If death was due to external causes, fill in the following:		
Cemetery or crematory <i>Rose Hill Cemetery</i>			Accident, suicide, or homicide..... Date of		
Location <i>Hagerstown, Md.</i>			Where did injury occur? (City or town) (County) (State)		
18. Funeral director <i>Wm H Downey</i>			Injured at home, farm, industry, public place (where?)		
Address <i>291 Frederick St Hagerstown</i>			Means of injury Injured at work?		
19. Sept. 21, 19 46 <i>Ernest F O'Connell</i> (Date rec'd by registrar) Registrar			23. SIGNATURE M, D, or other		
Address <i>Hagerstown Md</i> Date signed <i>9/20/46</i>					

RECEIVED
SEP 24 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R6-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County... Washington
 City or town... Rogers Heights
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 weeks
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hancock
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Anna Fisher Flowers

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Albert Flowers7. Birth date of deceased (mo., day, yr.) August 13, 1874 6. (c) If alive, give age 73 years8. AGE: Years Months Days If less than one day
72 0 26 — hrs. — min.9. Birthplace Fulton County, Penna.
 (Town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Silas Fisher
 13. Birthplace Penna.14. Maiden name Susan Strait
 15. Birthplace Penna.16. Informant Mr. Loney Flowers
 Address Rogers Heights, Md.17. Burial Date thereof Sept. 12, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Lutheran Church
 Location Rogers Heights, Md.18. Funeral director Charles R. Bast
 Address Hancock Md.19. 9-11-46 John Heller
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 9 19 46 at 9 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 19 45 to SEPT 9 19 46 and that I last saw him alive on SEPT 6 19 46.Immediate cause of death Arteriosclerotic Heart Disease
 Due to SENILITYMajor findings of operations Fracture Hip Right
Due to: Accidental fall
 Other conditions _____(Include pregnancy within 3 months of death)
 Major findings of operations Fracture Hip Right
 Date of op. May 1946
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of January 20th 1946
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) At home
 Means of injury Accidental fall Injured at work?23. SIGNATURE Archie Robert Cohen
 Address Clear Spring Ford Date signed 9/10/46

RECEIVED
SEP 14 1916
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

19337

★ Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 mo. 21 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 874 Virginia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Don Allen Gentry 3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 15, 1945 6. (c) If alive, give age _____ years

8. AGE: Years 10 Months 10 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown- Wash. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Samuel J. Gentry

13. Birthplace Dobson, N. Carolina

14. Maiden name Elaine Myers

15. Birthplace Hagerstown, Md.

16. Informant Samuel J. Gentry

Address 874 Va. Ave, Hagerstown, Md.

17. Burial Date thereof Sept. 7, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept 7 46 Registrar Clash Powers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1946 10:33 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/21 1946 and that I last saw him alive on 9/5 1946

Immediate cause of death Meningitis acute fulminans DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. D. Bowman M. D. or other

Address 7 Hagerstown Md Date signed 9/7/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 10 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

09338

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
630 Highland Way
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 630 Highland Way
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Florence Elizabeth Gigous

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Winter Gigous
 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 16, 1871

8. AGE: Years 75 Months 4 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co., Md.
 (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name Hezekiah Morgan
 13. Birthplace Wash. Co., Md.

MOTHER 14. Maiden name Alice Daugherty
 15. Birthplace Wash. Co., Md.

16. Informant Winter Gigous
 Address 630 Highland Way- Hagerstown, Md.

17. Burial Burial Date thereof Sept. 8-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Western Pike

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 7 1946 Shosh H. Powers
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1946 12:00 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Sept 5 1946
 and that I last saw him alive on Sept 5 1946

Immediate cause of death Cerebral Hemorrhage
 Due to Essential Hypertension
 Due to

DURATION

15 yrs

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE G. W. Swan M.D.
 M. D. or other

Address Bonshoro Date signed 9/6/46

RECEIVED

SEP 10 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington County Hosp.
 Length of mother's stay in County 22 yrs.
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 67 Broadway
 (If RURAL give LOCATION)

3. Name of child Baby Boy Harper
 5. Sex Male 6. Twin or triplet —

4. Date of birth Sept. 18, 1946 Hour 8:50 P. M.
 7. No. of weeks pregnancy 40

FATHER OF CHILD

8. Full name Roy Robert Harper
 9. Color W 10. Age at time of this birth 27 yrs.
 11. Usual occupation Clerk

MOTHER OF CHILD

12. Full maiden name Margaret Almeda Daniels
 13. Color W 14. Age at time of this birth 26 yrs.
 15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? no During labor? no
 18. Pregnancy, complications of Pre-eclampsia

19. Labor: (a) Complications of — (b) Induced? no
 20. (a) Was there an operation for delivery? yes (Yes or No)
 (b) State all operations, if any extraction
 (c) Did child die before operation? no
 During operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
 (a) Fetal causes —
 (b) Maternal causes —

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
 Signature Curtis Baptist, Jr.
 (Specify if M. D., midwife, or other)

Address 214 N. Calumet St.
 23. (a) Burial (b) Date thereof Sept. 19, 1946
 (Burial, cremation or removal) (month) (day) (year)
 (c) Cemetery or crematory Rose Hill Cemetery

24. (a) Funeral director St. J. Minnick, Ltd.
 (b) Address Hagerstown Md.
 25. (a) Sept. 19, 1946 (b) B. H. Howard
 (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.
 Health Officer, per —

* See Instruction C on stub.

Child lived 5 minutes

V. S. A10

T

RECEIVED

SEP 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County... WashingtonCity or town... Hancock
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Sue Ella Hayward

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife... Charles Hayward

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

July 10, 1866

8. AGE:

80

Years

1

Months

Days

29

If less than one day

hrs.

min.

9. Birthplace

Washington Co.
(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

FATHER

12. Name

George Gartner

13. Birthplace

Holland

MOTHER

14. Maiden name

Magdeline Fedder

15. Birthplace

Holland

16. Informant

Address

Edward Hayward
Hancock, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... Sept. 12, 1946
(month) (day) (year)Cemetery or crematory... St. Peter's Catholic Cem.Location... Hancock, Md.

18. Funeral director

Address

Snyder Rowland Funeral Home
Hancock, Md.

19. (Date rec'd by registrar)

9/12/46J. A. Veller
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 9, 1946 6:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 8 - 1946, to Sept 9 1946and that I last saw her alive on Sept 8, 1946

Immediate cause of death

Exhaustion

DURATION

Due to

Arteriosclerotic Heart Disease
Prototypical TachycardiaNot Known

Due to

Other conditions

Hypertension and generally
enlarged heart
(Include pregnancy within 8 months of death)Not Known

Major findings of operation

(See det. full report)1

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

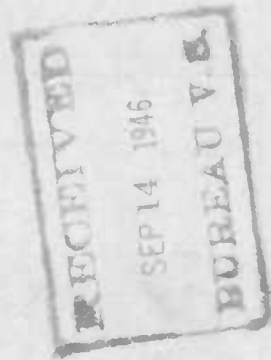
23. SIGNATURE

Edward Hayward
Hancock, Md.

M. D. or other

Address

Date signed 9/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

Dr. pitto

237

0934302
Reg. Dist. No.

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 Days</u> Hospital, institution, or street address where death occurred: <u>Washington County Hospital</u> How long in hospital or institution? <u>2 Days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>31 West Franklin st.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>None</u>			
3. (a) FULL NAME <u>Arthur Joseph Hendricks</u>				3. (b) Social Security Number <u>577-20-0579</u>			
4. Sex <u>Male</u> 5. Color or race <u>white</u> 6.(a) Single, married, widowed, or divorced <u>Widower</u>				MEDICAL CERTIFICATION P			
6.(b) Name of husband or wife <u>Besse</u> 6.(c) If alive, give age <u>-</u> years				20. DATE OF DEATH <u>September 3 1946</u> 19 <u>46</u> , at <u>11:55</u> <u>A.M.</u>			
7. Birth date of deceased (mo., day, yr.) <u>March 16 1871</u> 8. AGE: Years <u>75</u> Months <u>5</u> Days <u>17</u> If less than one day <u>hrs. min.</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>8-23-46</u> to <u>9-7-46</u> 19 <u>46</u> and that I last saw him alive on <u>9-7-46</u> 19 <u>46</u> Immediate cause of death <u>Cervical Fracture</u> DURATION <u>1 year</u>			
9. Birthplace <u>Fayette Seneca Co. N.Y.</u> (Town, county, and state)				Due to <u>Cervical Fracture</u>			
10. Usual occupation <u>Salesman-Retired</u>				Due to <u>Cervical Fracture</u>			
11. Industry or business <u>Automobile</u>				Other conditions <u>Cervical Fracture</u>			
FATHER 12. Name <u>William H. Hendricks</u> 13. Birthplace <u>Fayette N.Y.</u>				(Include pregnancy within 3 months of death)			
MOTHER 14. Maiden name <u>Malinda Backman</u> 15. Birthplace <u>Fayette N.Y.</u>				Major findings of operations <u>Cervical Fracture</u> Date of op. <u>9/6/46</u>			
16. Informant <u>Mrs. Gladys H. Wolf</u> Address <u>Hagerstown Md.</u>				Autopsy results <u>Cervical Fracture</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>Restvale Cemetery</u> Date thereof <u>9/6/46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Seneca Falls New York</u> Location <u>Andrew K. Coffman</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>Cervical Fracture</u> Date of <u>9/6/46</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>Cervical Fracture</u> Means of injury <u>Cervical Fracture</u> Injured at work? <u>Cervical Fracture</u>			
18. Funeral director <u>Andrew K. Coffman</u> Address <u>Hagerstown Md.</u>				23. SIGNATURE <u>Dr. Pitt</u> M. D. or other <u>Dr. Pitt</u> Address <u>Hagerstown Md.</u> Date signed <u>Sept. 5 1946</u>			
19. (Date recd by registrar) <u>Sept. 5 1946</u> Registrar <u>Dr. Pitt</u>				23. SIGNATURE <u>Dr. Pitt</u> M. D. or other <u>Dr. Pitt</u> Address <u>Hagerstown Md.</u> Date signed <u>Sept. 5 1946</u>			

RECEIVED
SEP 7 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No.

003301

1. PLACE OF DEATH:

County... Washington CountyCity or town... Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 65 yrs.

Hospital, institution, or street address where death occurred:

17 Fenton Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Williamsport, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Fenton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Higgins

3. (b) Social Security Number

None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife... Jacob Higgins

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Sept. 19 1880

8. AGE:	Years	Months	Days	If less than one day
<u>65</u>	<u>11</u>	<u>21</u>	hrs.	min.

9. Birthplace... Williamsport, REF #2 Md.
(Town, county, and state)10. Usual occupation... Housewife11. Industry or business... Home12. Name... David Hose13. Birthplace... Maryland14. Maiden name... Elizabeth Guessford15. Birthplace... Maryland16. Informant... Jacob HigginsAddress... 17 Fenton Ave. Williamsport Md.17. Burial Date thereof... Sept. 11 1986
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... St. Pauls CemeteryLocation... Near Clearspring Md.18. Funeral director... Edith V. LeafAddress... #7 Church St. Williamsport, Md.19. Date rec'd by registrar... Sept. 11 198620. Registrar... Mrs E Lee McE...21. Address... Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH... 9/8/86 19... at... 2 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/8/86 19... 9/8/86 19...and that I last saw him alive on 9/8/86 19...Immediate cause of death... Coronary Occlusion

DURATION

5 hrs.

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R. F. YoungAddress... Williamsport, Md. Date signed... 9/9/86

RECEIVED

SEP 14 1946

BUREAU V N

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

Rug. Dist. No. 09343 304

1. PLACE OF DEATH:

County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. West Sideling Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Bottenfield Hixon

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, or divorced

Female White Married6. (b) Name of husband as wife Jacob R. Hixon6. (c) If alive, give age 84 years7. Birth date of
deceased (mo., day, yr.) March 22, 18628. AGE: Years Months Days If less than one day
84 6 6 — hrs. — min.9. Birthplace Breezewood, Bedford Co., Penna.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Adam Karns Bottenfield13. Birthplace Bedford Co., Penna.14. Maiden name Sarah Ann Pee15. Birthplace Bedford Co., Penna.16. Informant Mrs. Patience H. HendershotAddress Hancock, Md. R.F.D. #117. Burial Date thereof Oct. 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Buck Valley Christian ChurchLocation Buck Valley, Penna.18. Funeral director Charles R. BastAddress Hancock, Md.19. 9/30/46 19. J. A. Heller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1946, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/16 1946 to 9/28 1946
and that I last saw him alive on 9/26 1946

Immediate cause of death

DURATION

Chronic Myocard

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address Hancock, Md. Date signed 9/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 1 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. B.B. Kneisy

271

09344

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred

Washington County Hosp.How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 823 Oak Hill Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (a) FULL NAME

George K. Hoffman

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Minnie Hoffman6. (c) If alive, give age 78 years

7. Birth date of

deceased (mo., day, yr.)

October 23, 1864

8. AGE:

Years

Months

Days

If less than one day

81111

---- hrs. ---- min.

9. Birthplace

Funkstown

(Town, county, and state)

10. Usual occupation

Owner, Dry goods store

11. Industry or business

Dry Goods

FATHER

12. Name

J. C. Hoffman

13. Birthplace

Shepardstown W. Va.

MOTHER

14. Maiden name

Clara J. Knode

15. Birthplace

Funkstown Md.

16. Informant

George K. Hoffman Jr.

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 27, 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1946 at PM21. I CERTIFY that death occurred on the data above stated; that I attended deceased from September 15, 1946, to September 24, 1946and that I last saw him alive on September 24, 1946 in

Immediate cause of death

Acute pulmonary edemaMyocarditis - chronic

DURATION

1/2 hr.Indef.

Due to

Due to

Other conditions Acute lobar pneumonia bilateral 10 day

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

B.B. Kneisy M.D.

M. D. or other

Address 148 W. Washington St. Date signed 9/25/46

RECEIVED
SEP 30 1946
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09345

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, institution, or street address where death occurred:
331 Jefferson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 331 Jefferson
(If rural, give LOCATION)
World War 1
2.(a) If veteran, name war

3. (a) FULL NAME

Frederick Thomas Hose Sr.

3. (b) Social Security Number

213-10-6888

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Olive A. Hose
6. (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) September 25, 1891
8. AGE: Years 55 Months 0 Days 0
If less than one day hrs. min.

9. Birthplace Hagerstown Wash. Md.
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business North American Cement Co.

12. Name William A. Hose
13. Birthplace Hagerstown Md.

14. Maiden name Margaret E. Baughman
15. Birthplace Near Newville Pa.

18. Informant Mrs. Olive A. Hose
Address Hagerstown Md.

17. Burial Date thereof Sept. 28-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.

19. Sept 28 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946 at 5 p. M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 25, 1946 to Sept. 25, 1946
and that I last saw him alive on 19

Immediate cause of death Coronary occlusion
DURATION 5 minutes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Bowers M.D. or other

Address 148 W. Washington St., Date signed 9/27/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 1 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 216 Summit Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

George R. Howlett

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife..... <u>Sarah Howlett</u>		
7. Birth date of deceased (mo., day, yr.) <u>Sept. 25, 1874</u>		
8. AGE: Years <u>69</u>	Months <u>11</u>	Days <u>27</u>
6. (c) If alive, give age..... years hrs. min.		

9. Birthplace..... <u>Virginia</u> (Town, county, and state)
10. Usual occupation..... <u>None</u>
11. Industry or business..... <u>Unknown</u>
FATHER
12. Name..... <u>"</u>
13. Birthplace..... <u>"</u>
MOTHER
14. Maiden name..... <u>"</u>
15. Birthplace..... <u>"</u>

16. Informant..... <u>George Howlett</u>
Address..... <u>216 Summit Ave- Hagerstown, Md.</u>

17. Burial.....	Date thereof..... <u>Sept. 24-46</u> (month) (day) (year)
Cemetery or crematory..... <u>Greenlawn Cemetery</u>	
Location..... <u>Williamsport, Md.</u>	

18. Funeral director..... <u>Fred W. Kraiss</u>
Address..... <u>Hagerstown, Md.</u>

19. <u>Sept. 23, 46</u>	Registrar..... <u>Blas H. Bowers</u>
(Date rec'd by registrar)	

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 21, 1946 19..... at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/18/46 to 9/21/46 and that I last saw him alive on 9/21/46

Immediate cause of death..... Periatal apoplexy

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... R. P. Young M. D. or other

Address..... Williamsport, Md. Date signed..... 9/23/46

RECEIVED
SEP 25 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

Dr. Porterfield

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 hours
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 8 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Wash. Cty. Hospital
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Thomas Edward Hume

3. (b) Social Security Number

no

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 B. (b) Name of husband or wife ----
 6. (c) If alive, give age ---- years
 7. Birth date of deceased (mo., day, yr.) Sept. 14, 1946
 8. AGE: Years --- Months --- Days --- If less than one day 8 hrs. --- min.

9. Birthplace Washington County Hospital
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business none
 12. Name Clarence Hume
 13. Birthplace Staunton, Va.
 14. Maiden name LaRena Shaw
 15. Birthplace Hagerstown, Md.
 16. Informant Clarence Hume
 Address Hagerstown, Md.
 17. Burial Date thereof Sept. 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown, Md.
 Location Andrew K. Coffman
 18. Funeral director Hagerstown, Md.
 Address Sept. 14 46
 19. (Date rec'd by registrar) Blanch Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1946 at 2:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1946 to Sept 14 1946
 and that I last saw him alive on Sept 14 1946

Immediate cause of death Premature Infant

DURATION

Due to -----Due to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury HB Porterfield MD Injured at work? no23. SIGNATURE HB. Porterfield MD. M. D. or otherAddress 136 W Washington Date signed 9/14/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians please write the causes of death clearly and legibly.

RECEIVED

SEP 17 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

D99348to

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
611 Sunset Ave.
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Calvert
 City or town Mutual
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R. F. D.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war yes

3. (a) FULL NAME

George Ireland

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary Louise
 6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) April 20, 1908

8. AGE: Years 38 Months 4 Days 19 If less than one day
 hrs. min.

9. Birthplace Mutual, Calvert Cty., Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name John Lattner Ireland

13. Birthplace Mutual, Md.

14. Maiden name Mary Dorsey

15. Birthplace Mutual, Md.

16. Informant Mrs. Mary L. Ireland

Address 611 Sunset Ave.

17. Burial Date thereof Sept. 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church Cemetery

Location Near Mutual, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Sept. 9, 46 Blackbourn
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1946 at 4:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7-9 1946 and that I last saw him alive on Sept 8-9 1946

Immediate cause of death

Chr. Myocarditis DURATION 10 yrs

Due to (Coronary Thrombosis) 36 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE EW Smith M. D. or other

Address Hagerstown, Md. Date signed 9/9/46

RECEIVED
SEP 11 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-

09349

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Rural Reid, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years
 Hospital, institution, or street address where death occurred:
Hagerstown, Route 6
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Rural Reid, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Route #6
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Doris M. Irving

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1917

8. AGE: Years 28 Months 11 Days 9 If less than one day
 hrs. min.

9. Birthplace Washington County, Maryland
 (Town, county, and state)

10. Usual occupation Housework11. Industry or business At Home

FATHER 12. Name Frank Irving
 13. Birthplace Beaver Creek, Maryland

MOTHER 14. Maiden name Julia Fulton
 15. Birthplace Beaver Creek, Maryland

16. Informant Mrs. Frank Irving
 Address Reid, Maryland

17. Burial Date thereof (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory Dunkard Cemetery 9-15-46
 Location Near Beaver Creek, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Sept. 24, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27, 46 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 20 - 46 to Sept 23 - 46
 and that I last saw her alive on Aug 10 - 46 19

Immediate cause of death

DURATION

Pulmonary T. B. 4 yrs
 Due to

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. Suter M. D. Registrar

Address Hagerstown, Md Date signed 9/24/46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 26 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (In correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. B.E. Kneisky 268

09350

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 116 Wayside Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Abraham Howard Keirn

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna Keirn
 6. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) April 7, 1867
 8. AGE: Years 79 Months 5 Days 16 It less than one day -- hrs. -- min.

9. Birthplace Altoona Blair Co. Penna.
 (Town, county, and state)
 10. Usual occupation Retired farmer
 11. Industry or business
 12. Name Tulbot Keirn
 13. Birthplace Altoona Penna.
 14. Maiden name Sarah Ellen Arble
 15. Birthplace Richland Penna.

16. Informant Mildred Keirn
 Address Hagerstown Md.
 17. Burial Date thereof Sept. 25, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Schwartz Cemetery
 Location Baltimore Co. Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Maryland
Sept. 23, 46
 19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 46 at 2:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 10, 1946 to Sept. 23, 1946
 and that I last saw him alive on September 22, 1946

Immediate cause of death Chronic myocarditis with congestive failure DURATION 4 yrs.

Due to

Due to

Other conditions General arteriosclerosis 10 yrs

Peripheral vascular (arterial) disease of lower extremities 1 yr
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE B. E. Kneisky M. D.

M. D. or other

Address 148 W. Washington St. Date signed 9/23/46

RECEIVED

SEP 25 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 147 W. Church Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 147 W. Church St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Frederick Keyser

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife
 6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Feby. 2, 1886
 8. AGE: Years 60 Months 7 Days 22 If less than one day hrs. min.

9. Birthplace Page County, Va.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Keyser
 13. Birthplace Page Co., Va.

MOTHER 14. Maiden name Pameleann Alger
 15. Birthplace Page Co., Va.

16. Informant Mrs. Mattie Clingan
 Address W. Church St.- Hagerstown, Md.

17. Burial Date thereof Sept. 20-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East Liberty Cemetery
 Location Shenandoah, Va.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 19, 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946 10 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1946 to Sept 17, 1946 and that I last saw him alive on Sept 17, 1946

Immediate cause of death Coronary Occlusion
 DURATION 1 hour

Due to
 Due to

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other
 Address [Signature] Date signed [Signature]

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 21 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

CERTIFICATE OF DEATH

09352

2

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
City or town near Soperland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Rural Soperland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lillian Gertrude Tidwell

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Wilford Tidwell

7. Birth date of deceased (mo., day, yr.) Apr 1876

6. (c) If alive, give age _____ years

8. AGE: Years 70 Month 5 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Mortimer Levine

13. Birthplace Virginia

14. Maiden name Susan Burkett

15. Birthplace Virginia

16. Informant Mrs. Mortimer Levine

Address Washington, D.C.

17. Burial Date thereof 9-21-46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Brunswick, Md.

18. Funeral director C.H. Tector and

Address Brunswick, Md.

19. Sept 20 1946 Dorceline H. Castle
(Date rec'd by registrar) (month) (day) (year) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1946, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 12 1946, to Sept. 19 1946, and that I last saw him alive on Sept. 17 1946.

Immediate cause of death _____

DURATION

Chronic Myocarditis 5 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. W. Selby M.D.

M. D. or other _____

Address Boonsboro Date signed 9/28/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 09353 305

1. PLACE OF DEATH:

County Washington
 City or town Cleavelandville - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Boonsboro Route 2
 Hospital, institution, or street address where death occurred:
- 5 years -
at home.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Cleavelandville - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Boonsboro Md. R. 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war none.

3. (a) FULL NAME

Clyde C. Koogle

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Bessie Koogle
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June - 22 - 1880
 8. AGE: Years 66 Months 3 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace near Middletown Fred. Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Own Farm

12. Name Clyde Koogle

13. Birthplace near Middletown Fred. Co. Md.

14. Maiden name Emma Shank

15. Birthplace near Middletown Fred. Co. Md.

16. Informant Mrs. Bessie Koogle

Address Boonsboro Md. R. 2

17. Burial Date thereof Sept 26, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Bast & Son

Address Boonsboro Md.

Sept. 24, 1946 John W. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 - 1946 at 4:30 A-M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 24 1946
 and that I last saw him alive on Sept 20 1946

Immediate cause of death Cerebral Hemorrhage DURATION 6 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J E Harp MD M. D. or other

Address Middletown Date signed 9-24-

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD RECEIPT

RECEIVED BY

RECEIVED
SEP 26 1946
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09354

242

★ Reg. Dist. No. 302

1. PLACE OF DEATH: County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>50</u> Hospital, institution, or street address where death occurred: <u>1017 Hamilton Blvd.</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Washington</u> City or town..... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>13 North Potomac St.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>Dora Lenora Magaha</u>				3. (b) Social Security Number <u>None</u>			
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow				MEDICAL CERTIFICATION			
6. (b) Name of husband or wife <u>Charles M. Magaha</u> 7. Birth date of deceased (mo., day, yr.) <u>Jan. 7, 1880</u> 8. AGE: Years <u>66</u> Months <u>7</u> Days <u>29</u> If less than one day hrs. min.				20. DATE OF DEATH <u>Sept 6 - 1946</u> at <u>11:30 A.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 2 - 1946</u> to <u>Sept 6 - 1946</u> and that I last saw <u>her</u> alive on <u>Sept 6 - 1946</u> Immediate cause of death..... <u>Chr. Myocarditis</u> <u>(Coronary Lesion)</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
9. Birthplace <u>Cumberland, Alleghany, Md.</u> (Town, county, and state) 10. Usual occupation <u>Housewife</u> 11. Industry or business				DURATION <u>2 yrs</u>			
12. Name <u>John Weibel</u> 13. Birthplace <u>Cumberland, Md.</u> 14. Maiden name <u>Elizabeth Schneider</u> 15. Birthplace <u>Germany</u>				Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.			
16. Informant <u>Mrs. Chauncey Kieffer</u> Address <u>Hagerstown, Maryland</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
17. Burial <u>Rose Hill</u> Date thereof..... <u>9 9 46</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... Location..... <u>Hagerstown, Md.</u>				23. SIGNATURE <u>EW Suter</u> M. D. or other <u>Hagerstown, Md.</u> Date signed..... <u>1946</u>			
18. Funeral director <u>C. M. Suter & Sons</u> Address <u>Hagerstown, Md.</u>				Address..... Date signed.....			
19. (Date rec'd by registrar) <u>Sept 9, 1946</u> Registrar <u>Phasch Bowers</u>				Address..... Date signed.....			

RECEIVED

SEP 11 1946

BUREAU V S

ARTISTIAN LEADER

CONTENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

0935502
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
343 S. Cannon Ave
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 343 S. Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

Emma Rose Marr

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife A. H. Marr
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September - 14 - 1854
8. AGE: Years 92 Months 0 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
12. Name William Wallick
13. Birthplace Wash. Co. Md.
14. Maiden name Elizabeth Long
15. Birthplace Washington Co. Md.

16. Informant Miss May Marr
Address 343 S. Cannon Ave. Hagerstown Md.
17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof October 1 - 1946
(month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.

18. Funeral director Wm J. Bowers
Address Boonsboro Md.
19. Sept. 30 46 Registrar Wm J. Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 19 46 at 6:40 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 45 to Sept 29 19 46
and that I last saw him on alive on Sept 28 19 46

Immediate cause of death Cardiac dilatation
Due to myocarditis
atherosclerosis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Hrs. Porterfield M.D.
Address 136 W Washington Date signed 9/30/46
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Porterfield

46

RECEIVED

OCT 2 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(170-C)

CERTIFICATE OF DEATH

09356

Reg. Dist. No. 300

1. PLACE OF DEATH:

County..... Washington
 City or town..... Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... W. Virginia County..... Jefferson
 City or town..... Shepherdstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... 4 F

3. (a) FULL NAME

Russell L. Muck

3. (b) Social Security Number

None

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Single

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 19 1946, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h..... alive on.....19.....

Immediate cause of death..... DURATION

Open fracture cervicalDue to..... vertebraFractured rt humerus (closed)

Due to.....

Open fracture (rt) femur

Other conditions.....

shock

(Include pregnancy within 8 months of death)

Major findings of operations.....

no

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... Sept. 19 46Where did injury occur?..... Sharpsburg Md. Wash.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... Shepherdston RdMeans of injury..... auto struck tree Injured at work?..... No

DEPUTY MEDICAL EXAM.

23. SIGNATURE..... Stokes Wells WASH. CO. MD.M. D. 9/20/46Address..... Hagerstown, Md. Date signed.....

6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... May 23, 1924
 8. AGE: Years..... 22 Months..... 4 Days..... 4 If less than one day..... hrs. min.
 9. Birthplace..... Shepherdstown-Jefferson-W. Virginia
 (Town, county, and state)
 10. Usual occupation..... Laborer
 11. Industry or business.....
 12. Name..... Samuel J. Muck
 13. Birthplace..... Shepherdstown, W. Virginia
 14. Maiden name..... Carrie Mitchell
 15. Birthplace..... Boonsboro, Maryland
 16. Informant..... James J. Muck
 Address..... Shepherdstown, W. Virginia
 17. Burial Date thereof..... Sept. 22, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Reformed
 Location..... Shepherdstown, W. Virginia
 18. Funeral director..... R. I. Earnshaw
 Address..... Keedysville, Md
 19. 9-21 19 46
 (Date rec'd by registrar) Registrar.....

RECEIVED
OCT 4 1948
BUREAU OF
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100-6)

09357

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 22 Roessner Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Anna Mary Myers

3. (b) Social Security Number

214-09-4069A

4. Sex..... Female
 5. Color or race..... White
 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Riley E. Myers
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... Sept. 5, 1880
 8. AGE: Years..... 66 Months..... 0 Days..... 4 It less than one day..... hrs. min.

9. Birthplace..... Franklin County, Penna.
 (Town, county, and state)

10. Usual occupation..... Home duties

11. Industry or business.....

FATHER 12. Name..... Joseph Ira Whitmere
 13. Birthplace..... Penna.

MOTHER 14. Maiden name..... Lina Ditto
 15. Birthplace..... Penna.

16. Informant..... Riley E. Myers
 Address..... 22 Roessner Ave. Hagerstown, Md.

17. Burial..... Burial Date thereof..... Sept. 13, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rest Haven Cemetery
 Location..... Hagerstown, Md.

18. Funeral director..... Fred W. Kraiss
 Address..... Hagerstown, Md.

19. Sept 12 46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 9, 1946 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 to Sept 9 1946
 and that I last saw him/her alive on Sept 9 1946

Immediate cause of death..... Thrombosis - Renal Veins
 DURATION..... 12 days

Other conditions..... Acute thrombotic phlebitis - Common iliac Veins
and Iliac Vein. 5 wks.

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... Philip J. Holman M.D.
 Address..... 159 W. Washington St Date signed..... 9/10/46

RECEIVED
SEP 14 1945
BUREAU V S

Evidence for change of age
of deceased is shown on

FILM No. I 07 OCT 15 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09358

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

105 Elizabeth Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Elizabeth Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Upton Myers

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Ivy C. Myers

7. Birth date of

deceased (mo., day, yr.)

July 28, 1887

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59

60 59

2

0

hrs. min.

9. Birthplace Washington County, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name Myers

MOTHER

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. Ivy C. Myers

Address 105 Elizabeth St. - Hagerstown, Md.

17. Burial Date thereof Oct. 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Hagerstown, Md.

Location Fred W. Kraiss

18. Funeral director Hagerstown, Md.

Address Hagerstown, Md.

19. Oct. 1, 46 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1946 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

chr. bronchial asthma 3 yrs

Due to

chr. myocarditis 2 yrs

Due to

acute ventricular fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

DEPUTY MEDICAL EXAM.

S. Robert Wells WASH. CO., MD.

23. SIGNATURE

Hagerstown, Md. M. D. Chas. H. Bowers

Address Hagerstown, Md. Date signed 9/30/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 3 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 512

CERTIFICATE OF DEATH

09359

Reg. Dist. No.

382

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

537 West Church St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 537 West Church St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Harry G. Nail

3.(b) Social Security Number

213-10-8134

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 28, 1888

8. AGE:

Years

58

Months

3

Days

20

If less than one day

hrs.

min.

9. Birthplace Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Harry G. Nail13. Birthplace Hagerstown, Md.

MOTHER

14. Maiden name Betty E. Gold15. Birthplace Hagerstown, Md.

16. Informant

Address Hagerstown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 20, 1946
(month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland.19. Sept. 19, 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946 19 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 9, 1944 to Sept. 17, 1946and that I last saw him alive on Sept 9, 1946

Immediate cause of death

DURATION

carcinoma of prostate5yrsDue to Tabes dorsalisDue to acute coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation carcinoma prostate 1941

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Hagerstown, Md. Date signed 9/18/46

RECEIVED

SEP 21 1946

BUREAU V M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

09360

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

19 North Mulberry Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 19 North Mulberry Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John H. Nichols, Jr.

3.(b) Social Security Number

212 -14-6495

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Edna B. Nichols

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

March 17, 1892

8. AGE:

Years

Months

Days

If less than one day

54

5

15

hrs. min.

9. Birthplace

Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Coca Cola Company

FATHER

12. Name

John H. Nichols

13. Birthplace

Hagerstown, Maryland

MOTHER

14. Maiden name

Mary E. Boward

15. Birthplace

Hagerstown, Maryland

16. Informant

Mrs. John H. Nichols, Jr.

Address

Hagerstown, Maryland

17.

Burial

Date thereof

9-4-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown, Maryland

C. M. Suter & Sons

18. Funeral director

Address

Hagerstown, Maryland

19.

9-3-

1946

(Date rec'd by registrar)

Registrar

Chas. H. Bowers

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-2-46

19

12:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-2-46

9-2-46

19

and that I last saw him

9-2-46

19

Immediate cause of death

Cerebral ischemia

DURATION

6 min.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. W. Suter

Address

Hagerstown, Md.

Date signed

9-4-46

RECEIVED
SEP 5 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 179

CERTIFICATE OF DEATH

Dr. S.R. Wells

09361

273

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? --

Hospital, institution, or street address where death occurred:

Middleburg PikeHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. National Airport
(If rural, give LOCATION)2.(a) If veteran, name war World War II ✓

3. (a) FULL NAME

George Wesley Orange / Captain AC

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Evelyn6. (c) If alive, give age 25 years7. Birth date of deceased (mo., day, yr.) March 4, 1919

8. AGE:	Years	Months	Days	If less than one day
<u>27</u>		<u>6</u>	<u>23</u>	<u>--</u> hrs. <u>--</u> min.

9. Birthplace Hagerstown Washington Co. Md.
(Town, county, and state)10. Usual occupation Captain Air Corps11. Industry or business Regular Army12. Name William A. Orange13. Birthplace Amelia Va.14. Maiden name Jemima L. Wallace15. Birthplace Hagerstown Md.16. Informant William A. OrangeAddress Cavetown Md.17. Burial Date thereof 9/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept. 30, 46 Chas. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 46 at 5:22 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death..... DURATION

Pulmonary HemorrhageDue to closed fracture rt humerusDue to closed fractures of ribs rtOther conditions hemorrhage & shock

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/27/46Where did injury occur Hagerstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Farm 4 mi. N ofMeans of injury Plane crash Injured at work? No cityDEPUTY MEDICAL EXAM. WASH. CO., MD.23. SIGNATURE S. R. Wells Hagerstown, Md. M. D. or Chas. BowersAddress..... Date signed 9/28/46

RECEIVED

OCT 2 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

CERTIFICATE OF DEATH

09362

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington Co
 City or town Caretown Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Martin Phetteplace

3. (b) Social Security Number

215-07-9417

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Levin M. Hise

7. Birth date of deceased (mo., day, yr.)

Jan. 7 - 18838. (c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

63422

hrs.

min.

9. Birthplace

Smithsburg Md.
(Town, county, and state)

10. Usual occupation

Farmer and Machine operator

11. Industry or business

Victor Products Co.

12. Name

J. H. Phetteplace

13. Birthplace

Providence R.I.

14. Maiden name

Elizabeth Martin

15. Birthplace

Germany

16. Informant

Mrs. Doris H. Hise

Address

Caretown, Md.17. Buried

(Burial, cremation, or removal. Which?)

Date thereof

10/1/46
(month) (day) (year)

Cemetery or crematory

Smithsburg

Location

Smithsburg Md

16. Funeral director

Walter J. Hise

Address

777 Church St. Mayfield, Pa.19. Sept 30

(Date rec'd by registrar)

19. 4619. 46Geo W. Ferguson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Washington
 City or town Caretown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 29 19. 46 at 12:10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 21 19. 46 to Sept 29 19. 46

and that I last saw him alive on

Sept 29 19. 46

Immediate cause of death

Pulmonary Emboli

DURATION

3 days

Due to

mesenteric thrombosis

Due to

arterial sclerosis

Other conditions

()

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Phetteplace
M. D. or other

Address

Smithsburg

Date signed

9/30/46

CERTIFICATE OF DEATH

RECEIVED
OCT 9 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09363

202

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Thurs Leo HoopStay in hospital or inst. (yrs., or mos., or days) 116 daysStay in this community (yrs., or mos., or days) about 19 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WashingtonCity or town Hagerstown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 70 E IVIR

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Minnie A Quail

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6 (b) Name of husband or wife Herbert V Quail

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 Oct 73

8. AGE:

Years

72

Months

11

Days

15

If less than one day

hrs. min.

9. Birthplace Baltimore City, Md

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business run home12. Name Daniel M. Walhelm13. Birthplace Black Rock, Balto. Co., Md14. Maiden name Charlotte Bosson15. Birthplace Baltimore Co., Md16. Informant Herbert V. Quail (husband)Address Hagerstown, Md17. Burial Date thereof Sept. 18, 1946

(Burial, cremation, or disposal. Which?) (month) (day) (year)

Cemetery or crematory David Ridge CemeteryLocation Pikesville, Md18. Funeral director Edward C. TeptonAddress Hampstead, Md19. Sept. 16, 1946 Registrar Frank H. Bowers

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Sept 19 46, at 9: P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Feb 19 46, to 15 Sept 19 46and that I last saw her alive on 15 Sept 19 46

Immediate cause of death

Generalized Arterio sclerosis with myocardial Failure

DURATION

about 10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE J J Lusby

M. D. or other

Address 230 N PotomacDate signed 16 Sept 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 24 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09364

Reg. Dist. No. 144 305

1. PLACE OF DEATH:

County WashingtonCity or town Seatons Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County FredricksCity or town Thurmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Celine Alberta Recher

3. (b) Social Security Number

no

4. Sex

F

5. Color or race

W

6. (d) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife John L. Recher7. Birth date of deceased (mo., day, yr.) Feb. 13-1872

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7476hrs min.9. Birthplace Garfield Fredk Co Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John H. Torms13. Birthplace Garfield Fredk Co Md14. Maiden name Grantha Wolfe15. Birthplace Garfield Fredk Co Md16. Informant Mrs Jimbro ScottAddress Brownstown P.O. 2. Md17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Sept 22-46Cemetery or crematory N. B. CohnLocation Thurmont Md18. Funeral director M. L. Creager DanAddress Thurmont Md19. Sept. 21 1946 Blanche S. Egle

(Date rec'd by registrar)

John H. East

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 46, at 6:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 12, 1946 19 46 to Sept. 19, 1946and that I last saw h er alive on September 18, 1946 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 months

Due to _____

Due to _____

Other conditions Chronic nephritis 3 yrsChronic myocarditis with cong. failure 3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. B. Kneisky M.D.

M. D. or other

Address 148 W. Washington St. Hagerstown 9/20/46

RECEIVED
SEP 25 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 09365 303

1. PLACE OF DEATH:
 County Washington
 City or town Clear Spring Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Clear Spring Rural #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Lewis Lee Renner 3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Barbara Renner

7. Birth date of deceased (mo., day, yr.) July 4 - 1853 6. (c) If alive, give age _____ years

8. AGE: Years 93 Months 2 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Washington Co.
 (Town, county, and state)

10. Usual occupation Saddler

11. Industry or business Self Employed

12. Name John Renner

13. Birthplace Washington Co.

14. Maiden name Matilda Wishard

15. Birthplace Washington Co.

16. Informant Mrs. John Grace

Address Clear Spring Rural 1

17. Burial Date thereof Oct 3 - 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery St Pauls Cemetery

Location Near Clear Spring Md

18. Funeral director Snyder-Rawland

Address Clear Spring Md

19. Oct 2 19 46 Lucy M. Zoller
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 46 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 40 to Sept 30 19 46
 and that I last saw him alive on Sept 22 19 46

Immediate cause of death _____ DURATION _____

Chr. Myocardial 2 yrs

Due to Atherosclerosis

Due to Arterio Sclerosis 10 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations X X Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or other _____

Address Clear Spring Md Date signed 9/30/46

CERTIFICATE OF DEATH

RECEIVED
OCT 9 1946
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

Dr. Wells

09366

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 years
 Hospital, institution, or street address where death occurred:
221 E. Baltimore St.
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 221 East Baltimore
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3. (a) FULL NAME

Mrs. Susan Werst Renner

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Charles E. Renner

7. Birth date of deceased (mo., day, yr.) August 13, 1866 6.(c) If alive, give age years

8. AGE: Years 80 Months -- Days 17 If less than one day hrs. min.

9. Birthplace Newville, Pa.
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business none12. Name Eli Werst13. Birthplace Newville, Pa.14. Maiden name Rachel Hefflefinger15. Birthplace Newville, Pa.16. Informant Mrs. E. R. SmithAddress 221 E. Baltimore St.

17. Burial Date thereof Sept. 11-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

19. Sept. 10 1946 Registrar Phas H. Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1946 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1937 to Sept. 8, 1946
 and that I last saw him alive on Sept. 8, 1946

Immediate cause of death Vascular hypertension DURATION 15 yrs.Due to cerebral hemorrhage 9 yrs.Due to hypostatic pneumonia 3 d

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Robert Wells M.D.

Signature, Md. Date signed 9/7/46
 Address

RECEIVED
SEP 12 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of
age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. I 07 OCT 8 1946 CERTIFICATE OF DEATH.

Reg. Diat. No. 32

1. PLACE OF DEATH:

County Washington
City or town mt. Airia Road Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
Hagerston md. R. 3
How long in hospital or institution? 6 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington
City or town: mt. aetha Road - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Md. R. 3
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME

Edna Elizabeth Reynolds

3. (b) Social Security Number

None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
8. (b) Name of husband or wife Edward L. Reynolds.		8. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January - 5 - 1905		
8. AGE:	Years	Months
47	11	13
	Days	If less than one day
	 hrs. min.

MEDICAL CERTIFICATION

2D, DATE OF DEATH.....13 September 1946 at 12³⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to 13 Sept 1946 and that I last saw her alive on 8 Sept 1946

Immediate cause of death.....
Indeterminate carcinoma.....

DURATION
2-3 mo.

Due to constriction of uterus and
body of uterus. 8 mo

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations.....
Cells interrogated..... Date of op. Feb 4 6

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of Injury 1 Injured at work? 0

Signature H. D. Lammie, msc

23. SIGNATURE _____ D. or other
Address _____ Date signed _____

9. Birthplace... Wagonsburg, Arizona
(Town, county, and state)

10. Usual occupation... House Wife

11. Industry or business... Own Home

MOTHER

FATHER

12. Name... George West

13. Birthplace... Pennsylvania

14. Maiden name... Cora (not known)

15. Birthplace... Pennsylvania

16. Informant... Edward E. Reynolds

Address... Hagerstown Md. R. 3

17. Buried Date thereof... Sept. 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Rest + Lawn Cemetery

Location... Hagerstown Md.

18. Funeral director... Wm. J. Bart & Sons.

Address... Boonsburg Md.

19. Sept 14 1946 Shelby P. Woods
(Date rec'd by registrar) Registrar

RECEIVED

SEP 17 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09368

Reg. Dist. No. 30.2

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 623 Frederick Street
 (If rural, give LOCATION)
 2.(d) If veteran, name war.....

3. (a) FULL NAME

Gertrude Mae Ringer

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleWhiteWidow6. (b) Name of husband or wife T. Biser Ringer

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 12, 18828. AGE: Years 64 Months 2 Days 25 It less than one day
..... hrs. min.9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)
Housework

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Frederick Grimm
13. Birthplace Hagerstown, MarylandMOTHER 14. Maiden name Susan Johnson
15. Birthplace Hagerstown, Maryland16. Informant Lewis D. Ringer
Address Hagerstown, Maryland17. Burial Date thereof 9-9-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland
C. M. Suter & Sons18. Funeral director.....
Address Hagerstown, Maryland19. Sept 9, 1946 Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, 1946 at 11:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1939 to Sept 6, 1946
and that I last saw her alive on Sept 6, 1946Immediate cause of death Shrinking of pyloric vein
Infarct + bulb of pylorus
Due to Carcinoma of stomach
Due to.....DURATION 3 weeks
5 yrs.Other conditions.....
(Include pregnancy within 8 months of death)Major findings of operations.....
Date of op.....Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)Injured at home, farm, industry, public place (where).....
Means of injury..... Injured at work?23. SIGNATURE B. R. Rether, M.D.
Address Hagerstown Date signed 9/7/46

RECEIVED

SEP 11 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Dr. Hornbaker

2

09369

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Security
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 69 Years
 Hospital, institution, or street address where death occurred:
Security
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Security Road
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war None

3. (a) FULL NAME

CHARLES EDGAR ROWE

3. (b) Social Security Number

176-07-8598A

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Jennie F. Rowe
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) Dec. 3, 1876
 8. AGE: Years 69 Months 9 Days 27 It less than one day
 --- hrs. --- min.

9. Birthplace Hagerstown Washington Co. Md.
 (Town, county, and state)

10. Usual occupation Engineer

11. Industry or business Stationary

12. Name Levi S. Rowe

13. Birthplace Ringold Maryland

14. Maiden name Sarah C. Wise

15. Birthplace Hagerstown Maryland

16. Informant Mrs. Jennie F. Rowe

Address Security Maryland

17. Burial Date thereof Oct. 2, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown

18. Funeral director Andrew K. Coffman

Address Hagerstown Maryland

19. Oct. 2, 1946 Registrar Chas. B. Bower
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1946 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/3 1946 to 9/30 1946 and that I last saw him alive on 9/29 1946

Immediate cause of death Acute coronary occlusions DURATION 12 days

Due to Arteriosclerotic Heart Disease 7 mo -
(Symptomatic)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Hornbaker M.D. M. D. or other

Address 154 W. Washington St. - Hagerstown, Md. Date signed 9-30-46

RECEIVED
OCT 4 1946
BUREAU 18

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

Country Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years
 Hospital, institution, or street address where death occurred:
1021 Potomac Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1021 Potomac Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Peter N. Samios

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Maria Samios
 6.(c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.) Sept. 17, 1893
 8. AGE: Years 53 Months 0 Days 3 If less than one day
 hrs. min.

9. Birthplace Kythera, Greece
 (Town, county, and state)
 10. Usual occupation Restaurant Proprietor
 11. Industry or business Keystone Restaurant
 12. Name Nicholas Samios
 13. Birthplace Kythera, Greece
 14. Maiden name Stamatina Kyprioti
 15. Birthplace Kythera, Greece

16. Informant Mrs. Peter N. Samios
 Address Hagerstown, Maryland
 17. Burial Burial Date thereof 9-22-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
C. M. Suter & Sons
 18. Funeral director
 Address Hagerstown, Maryland
Sept 22 46
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept/20 1946 19 4:30 21 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19
 and that I last saw him alive on 19

Immediate cause of death acute coronary occlusion DURATION 30min
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. No Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

DEPUTY MEDICAL EXAM.
S. Robert Wells WASH. CO., MD.
 23. SIGNATURE Blair H. Bowers M. D.
Hagerstown, Md Date signed 9/21/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

CERTIFICATE OF DEATH

09371

267

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs
 Hospital, institution, or street address where death occurred:
237 Suters Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 237 Suter's Ave
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

John B. Shatzer

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Emma Shatzer
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 6, 1864
 8. AGE: Years 82 Months 4 Days 11 If less than one day hrs. min.

9. Birthplace Franklin Co., Pa.
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business

FATHER 12. Name Unknown Shatzer
 13. Birthplace Penn.
 MOTHER 14. Maiden name Unknown
 15. Birthplace Penn.

16. Informant Mrs. Ethel M. Boward
 Address 237 Suter's Ave. Hagerstown, Md.

17. Burial Data thereof Sept. 19, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belle Vue Cemetery
 Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
 Address Hagerstown, Md.

19. Sept. 23, 46 Phyllis Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1946 11:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 to Sept 17 and that I last saw him alive on Sept 3

Immediate cause of death Stroke & arteriosclerosis of heart & vessels
Chronic myocarditis

DURATION
6 mo.
6 mo.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Phyllis Bowers M. D. or other

Address 159 W. Washington St. Date signed 9/18/46

RECEIVED

SEP 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09372

257

FILM No. I 07 OCT 7 1946

CERTIFICATE OF DEATH

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington County
 City or town Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 Hrs.
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 48 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Williamsport, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Fenton Ave. Williamsport, Md.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Mrs. Lydia Mae Miller Shawyer

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife William J. Shawyer
deceased 6.(c) If alive, give age _____ years

7. Birth data of deceased (mo., day, yr.) Sept. 19 1875

8. AGE: Year 70 Months 11 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Williamsport, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name James J. Miller

13. Birthplace Smithburg Md.

14. Maiden name Laura Crilley

15. Birthplace Hagerstown Md RFD

16. Informant Mr. Clyde Miller (son)

Address 37 Salisbury St. Williamsport, Md.

17. Burial Date thereof Sept. 19 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Md.

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md.

19. Sept. 18, 46 Registrar Chas. Powers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 17 1946 to Sept 17 1946 and that I last saw him alive on Sept 17 1946

Immediate cause of death Coronary Occlusion DURATION 48 hrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Chas. Powers M. D. or other _____

Address Williamsport, Md. Date signed 9/18/46

RECEIVED
SEP 20 1946
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09373

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pennsylvania County Franklin
City or town Chambersburg R. D. 6
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name was _____

3. (a) FULL NAME

Susan Shupp

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Hiram Shupp

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1882 6. (c) If alive, give age _____ years

8. AGE: Years 64 Months 7 Days 22 It less than one day _____ hrs. _____ min.

9. Birthplace Franklin County, Pa.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Samuel Parmer
13. Birthplace Franklin Co., Pa.

14. Maiden name Weaver
15. Birthplace Franklin Co., Pa.

16. Informant Mr. Hiram Shupp
Address Chambersburg, Pa. R D 6

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 22-46
(month) (day) (year)

Cemetery or crematory Reiff's Mennonite Cemetery
Location Cearfoss, Md.
Fred W. Kraiss

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. (Date rec'd by registrar) Sept. 22, 46 Registrar Blanch Howard

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1946 7:55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13, 1946 to Sept 19, 1946 and that I last saw her alive on Sept 18, 1946

Immediate cause of death gangrene of left leg DURATION 1 wk

Due to Embolism popliteal artery 1 wk

Due to Auricular fibrillation
Arterio-sclerotic heart disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations Amputation left leg above knee Date of op. Sept 17, 1946

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE P. J. Stauffer, M.D. M. D. or other
Address Hagerstown, Md. Date signed Sept 19, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 24 1946
BUREAU T S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Big Pool Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Big Pool Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Abner Jackson Smith

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 10 1862
 8. AGE: Years 84 Months 5 Days 13 If less than one day
 hrs. min.

9. Birthplace Madison Co., Va.
 (Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

12. Name Gabriel Smith
 13. Birthplace Madison Co. Va.

14. Maiden name Evalin Davis
 15. Birthplace Madison Co. Va.

16. Informant Edward Smith
 Address Big Pool. Rural

17. Burial Date thereof Sept 27 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Shanktown Cemetery
 Location Near Big Pool, Md.

18. Funeral director Snyder-Rowland
 Address Clearspring, Md.

19. Sept 25 19 46 Joseph W. Murray
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 46 at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 22 19 46 to Sept 24 19 46
 and that I last saw him alive on Sept 23 19 46

Immediate cause of death Acute Cardiac Failure
 Due to Arterio sclerosis
 Due to Myocardial Sclerosis
 Other conditions
 (Include pregnancy within 8 months of death)

DURATION

2 days

10 yrs

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE David P. Brewer
Clear Spring Md.
 Address Clear Spring Md. Date signed 9/24/46

RECEIVED
SEP 27 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (111a)

CERTIFICATE OF DEATH

Reg. Dist. No. 09375-9as-

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1.5 years
 Hospital, institution, or street address where death occurred:
S. Main St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. S. Main St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Beulah Catherine Smith

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Edward Smith
 7. Birth date of deceased (mo., day, yr.) March - 20 - 1896 6.(c) If alive, give age years
 8. AGE: Years 50 Months 6 Days 7 If less than one day hrs. min.

9. Birthplace near Keedysville Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business own home

12. Name Charles E. Line

13. Birthplace Church Hill Fred. Co. Md.

14. Maiden name Emma Brandenburg

15. Birthplace near Middletown Fred. Co. Md.

16. Informant Mrs. Paul May

Address Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 29, 1946
 (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Best & Sons

Address Boonsboro Md.

19. Sept. 28, 1946 John H. Best Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1946 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1946, to Sept. 27 1946
 and that I last saw her alive on Sept. 27 1946

Immediate cause of death Pulmonary Embolus

Due to Arterio in Patellar space

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. L. M. D.

Address Boonsboro Date signed Sept. 28, 1946

RECEIVED
OCT 1 1946
BUREAU OF
INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 09376 302

1. PLACE OF DEATH:

County Washington County
 City or town 111 West Side Ave. Hagerstown Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10
 Hospital, institution, or street address where death occurred:
111 West Side Ave. Hagerstown Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 111 West Side Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Frank Leroy Smith

3. (b) Social Security Number

214-09-5117

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Lelia Smith
 6.(c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) Dec. 22 1888
 8. AGE: Years 57 Months 8 Days 12 If less than one day
hrs. min.

9. Birthplace Smithburg Md.
 (Town, county, and state)
 10. Usual occupation Leather Cutter
 11. Industry or business Shoe & Legging Co.
 12. Name Thomas Smith
 13. Birthplace Smithburg Md.
 14. Maiden name Flora Reynolds
 15. Birthplace Smithburg Maryland

16. Informant Lelia Smith
 Address 111 West Side Ave. Hagerstown
 17. Burial Burial Date thereof Sept. 6 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. View Cemetery
 Location Sharpsburg Maryland
 18. Funeral director Edith V. Leaf
 Address #7 Church St. Williamsport, Md.
 19. Sept 5, 46 Shasth Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 September 1946 at 1:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that it attended deceased from
7 June 1946 to 3 September 1946
 and that I last saw him alive on 3 September 1946
 Immediate cause of death Arterio-sclerotic
cardio-vascular disease with
myocardial failure.

DURATION

unknown

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations none Date of op.
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE F.F. Lusby M. D.
 Address 230 N. Potomac St. Date signed 4 Sept. 46
Hagerstown, Md.

RECEIVED
SEP 7 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

09377

★ Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 year
 Hospital, institution, or street address where death occurred:
1031 Corbett St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1031 Corbett St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... none

3. (a) FULL NAME

David Emory Stine

3. (b) Social Security Number

None

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Widowed
 B. (b) Name of husband or wife... Clara Ellen Baker
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... Sept. 23, 1857
 8. AGE: Years... 88 Months... 11 Days... 15 If less than one day... hrs. min.

9. Birthplace... Sharpsburg, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation... Stone Mason
 11. Industry or business... (Retired)
 12. Name... Jacob Stine
 13. Birthplace... Wash. Co. Md.
 14. Maiden name... Nancy Greenawald
 15. Birthplace... Wash. Co. Md.

16. Informant... Mrs. Russell Arnold
 Address... 1031 Corbett St. Hagerstown Md.
 17. Burial... Burial Date thereof... September 10, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Church of the Brethren Cemetery
 Location... Beaver Creek Md.
 18. Funeral director... Wm. J. East & Sons
 Address... Boonsboro Md.
 19. Sept. 9, 1946 Phyllis Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... September-8- 1946 at 2:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 1, 1944 to Sept 8, 1946
 and that I last saw him alive on Sept 8, 1946
 Immediate cause of death...

Ch. Myocarditis

DURATION

6 yrs

Due to...
 Due to...
 Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Robert P. Conrad, M.D.
 Address... Hagerstown, Md. Date signed... 9-9-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Conrad

RECEIVED

SEP 11 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of date
of death and time of death
is shown on
G107 9/20/46

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 48-6

CERTIFICATE OF DEATH

Dr. Poole

093782
Reg. Dist. No. 302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>36 years</u> Hospital, institution, or street address where death occurred: <u>17 McComas Street</u> How long in hospital or institution? <u>None</u>			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>17 McComas St.</u> (If rural, give LOCATION) <u>No</u> 2. (a) If veteran, name war		
3. (a) FULL NAME <u>Mrs Mary M. Strausbaugh</u>			3. (b) Social Security Number <u>None</u>		
4. Sex <u>Female</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Widow</u>					
6. (b) Name of husband or wife <u>James</u>					
6. (c) If alive, give age years					
7. Birth date of deceased (mo., day, yr.) <u>Oct. 24, 1871</u>					
8. AGE: Years <u>74</u>		Months <u>10</u>		Days <u>15</u> If less than one day hrs. min.	
9. Birthplace <u>Thurmont, Frederick, Co., Md.</u> (Town, county, and state)					
10. Usual occupation <u>Housewife</u>					
11. Industry or business <u>Own Home</u>					
FATHER	12. Name <u>Jacob Green</u>				
	13. Birthplace <u>Thurmont, Maryland</u>				
MOTHER	14. Maiden name <u>Isabel Hancock</u>				
	15. Birthplace <u>Thurmont, Maryland.</u>				
16. Informant <u>Mrs Fannie Carlton</u> Address <u>Hagerstown, Maryland</u>					
17. Burial <u>Sept 11, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Rest Haven Cemetery</u> Location <u>Hagerstown, Maryland</u> Funeral director <u>Andrew K. Coffman</u> Address <u>Hagerstown, Maryland,</u>					
19. Sept 10, 46 (Date rec'd by registrar) Registrar					
MEDICAL CERTIFICATION					
20. DATE OF DEATH <u>September 8, 1946</u> at <u>11 P.M.</u>					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Sept 10, 46</u> to <u>Sept 8, 1946</u> and that I last saw him alive on <u>Sept 8, 1946</u>					
Immediate cause of death <u>Carcinoma uterus</u>					
Duration <u>1 yr</u>					
Due to <u>uterine hemorrhage</u> <u>6 wks.</u>					
Due to					
Other conditions					
(Include pregnancy within 3 months of death)					
Major findings of operations					
Date of op.					
Autopsy results					
PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following:					
Accident, suicide, or homicide..... Date of					
Where did injury occur? (City or town) (County) (State)					
Injured at home, farm, industry, public place (where?)					
Means of injury Injured at work?					
23. SIGNATURE <u>Ernest F. Poole, M.D.</u> M. D. or other Address <u>Hagerstown, Md</u> Date signed <u>9/9/46</u>					

RECEIVED
SEP 12 1946
BUREAU V D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

09379

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
1621 Virginia Ave.
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1621 Virginia Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War 11

3. (a) FULL NAME

Phyllis R. Trone

3. (b) Social Security Number

no

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife none
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 4, 1910
 8. AGE: Years 35 Months 11 Days 10 It less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Md.
 (Town, county, and state)

10. Usual occupation Nurse

11. Industry or business Private

12. Name Frank Trone

13. Birthplace Hagerstown, Md.

14. Maiden name Laura E. Spigler

15. Birthplace Hagerstown, Md.

16. Informant Frank Trone

Address Hagerstown, Md.

17. Burial Date thereof Sept. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Sept. 17, 46 Black Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1946 at 1:30 P. M.

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

DURATION

gun shot wound into chest
 Due to cavity in region of heart

hemorrhage & shock
 Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Sept 14 '46

Where did injury occur? Hagerstown, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Self-inflicted gun shot Injured at work? No

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE J. Robert Wells M. D. or other _____

Address Hagerstown, Md. Date signed 9/16/46

RECEIVED

SEP 19 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

09380

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Co. Hosp.How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn. County FranklinCity or town Mercersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war no ✓

3. (a) FULL NAME

(Mrs.) Blanche Ellen Trout

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Harry Trout

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 18808. (c) If alive, give age 68 years

8. AGE:

Years

66

Months

6

Days

28

If less than one day

_____ hrs. _____ min.

9. Birthplace

New York

(Town, county, and state)

10. Usual occupation

House keeper

11. Industry or business

FATHER

12. Name

Joseph Peavy

13. Birthplace

New York

MOTHER

14. Maiden name

Sarah Michaels

15. Birthplace

Penna.

16. Informant

Harry E. Trout

Address

Mercersburg, Pa.

17.

(Burial, cremation, or removal method?)

Buried

Date thereof

9/20/46

(month) (day) (year)

Cemetery or crematory

Fairview Cem.

Location

Franklin Co., Pa.

18. Funeral director

McNininger

Address

Mercersburg, Pa.

19.

(Date rec'd by registrar)

Sept. 18, 1946Blanche Trout

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-17-46 at 5:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-3-46 to 9-17-46and that I last saw him or alive on9-17-46

Immediate cause of death

acute coronary occlusion

DURATION

3 wks.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Horn Baker M.D.

M. D. or other

Address

154 W. Wash. St.

Date signed

9-18-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH

5. PLACE OF BIRTH (City, State, and Country)

6. OCCUPATION

7. CAUSE OF DEATH (Immediate Cause)

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF OTHERS

17. SIGNATURE OF OTHERS

18. SIGNATURE OF OTHERS

19. SIGNATURE OF OTHERS

20. SIGNATURE OF OTHERS

21. SIGNATURE OF OTHERS

22. SIGNATURE OF OTHERS

23. SIGNATURE OF OTHERS

24. SIGNATURE OF OTHERS

25. SIGNATURE OF OTHERS

26. SIGNATURE OF OTHERS

27. SIGNATURE OF OTHERS

28. SIGNATURE OF OTHERS

29. SIGNATURE OF OTHERS

30. SIGNATURE OF OTHERS

31. SIGNATURE OF OTHERS

32. SIGNATURE OF OTHERS

33. SIGNATURE OF OTHERS

34. SIGNATURE OF OTHERS

35. SIGNATURE OF OTHERS

36. SIGNATURE OF OTHERS

37. SIGNATURE OF OTHERS

38. SIGNATURE OF OTHERS

39. SIGNATURE OF OTHERS

40. SIGNATURE OF OTHERS

41. SIGNATURE OF OTHERS

42. SIGNATURE OF OTHERS

RECEIVED
SEP 20 1946
BUREAU V N

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (314)

Dr. Prather

CERTIFICATE OF DEATH

★ 09381302
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 Day
 Hospital, institution, or street address where death occurred:
40 Elizabeth
 How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 800 McCabe Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war NO ✓

3. (a) FULL NAME

James M. Whalen

3. (b) Social Security Number

213-16-3099

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) September 8, 1892
 6. (c) If alive, give age 54 years

8. AGE: Years 54 Months 0 Days 9 If less than one day hrs. min.

9. Birthplace Baltimore City
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Thomas Whalen13. Birthplace Baltimore, Md.14. Maiden name Mary Ann Gallagher15. Birthplace Baltimore, Md.16. Informant Mrs Chas. WolfeAddress Hagerstown, Md.

17. Burial Date thereof Sept. 20, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer CemeteryLocation Baltimore, Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown, Md.

19. Sept. 18, 1946 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1946, at 11: AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17, 1946 to Sept 17, 1946
 and that I last saw him alive on Sept 17, 1946

Immediate cause of death Acute Myocarditis DURATION

Due to Chronic alcoholismDue to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Prather M. D. or otherAddress Hagerstown Date signed 9/17/46

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 20 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County... WashingtonCity or town... Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Boonsboro
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war... None

3. (a) FULL NAME

Ralph A. Wilhide

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Feb. 6, 1897

6.(c) If alive, give age years

8. AGE:

Years

49

Months

7

Days

10

If less than one day

..... hrs. min.

9. Birthplace... Keedysville-Wash.-Maryland

(Town, county, and state)

10. Usual occupation

Produce

11. Industry or business

FATHER

12. Name

John D. Wilhide

13. Birthplace

Middletown, Maryland

MOTHER

14. Maiden name

Alice M. Knadler

15. Birthplace

Keedysville, Maryland

18. Informant

Mrs. John D. Wilhide

Address

Boonsboro, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof... Sept. 18, 1946
(Month) (day) (year)

Cemetery or crematory

Fair-View

Location

Keedysville, Md

18. Funeral director

R. I. Earnshaw

Address

Keedysville, Md19. Sept. 17, 1946
(Date rec'd by registrar)19. 46John H. Bask
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 16, 1946, at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Ralph 2 - 1946, to Sept. 16, 1946
and that I last saw him alive on Sept. 15, 1946

Immediate cause of death

Hemiparesis

DURATION

4 days

Due to

Nephritis & Chronic Myocarditis14 days

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Robert M. Bask
M. D. or otherAddress... Boonsboro, Md. Date signed 9/16/46

REL
SEP 19 1941
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Dr. Wells

09383

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Mo.
 Hospital, institution, or street address where death occurred:
251 Bryan Place
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 251 Bryan Place
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

J. W. Willen

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 24, 1886
 8. AGE: Years 59 Months 11 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace St. Louis Missouri
 (Town, county, and state)
 10. Usual occupation Traffic manager
 11. Industry or business American Fruit Growers
 12. Name Vernard Willen
 13. Birthplace Germany
 14. Maiden name Elizabeth Leubenjans
 15. Birthplace Germany

16. Informant Mrs. Elizabeth W. Lee
 Address Arlington, Va.
 17. Burial Date thereof Sept. 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rosedale Cemetery
 Location Martinsburg, W. Va.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown, Md.
 19. Sept 13, 1946 Blanch Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH Sept./11 1946 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Vascular hypertension
 Due to angina pectoris
 Due to acute coronary occlusion
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide no Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.
 Address Hagerstown, Md. Date signed Sept. 11/46

RECEIVED
SEP 16 1946
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

CERTIFICATE OF DEATH

09384
Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 44 W. North Street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Susan Williams

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Birch Williams

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 6, 18838. AGE: Years 62 Months 11 Days 29 If less than one day _____ hrs. _____ min.9. Birthplace Marion S.C.
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name William Neal13. Birthplace Marion S.C.14. Maiden name Sager Scott15. Birthplace Marion, S.C.16. Informant Mrs. Mary L. MorrisowAddress 44 W. North Street17. Burial Date thereof 9/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Md.18. Funeral director William A. ConwayAddress 496 Frederick St. HagerstownDate rec'd by registrar Sept. 9, 46Registrar Chas. H. Howard

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 4 19 46 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 16 19 46 to Sept 4 19 46and that I last saw her alive on Sept 3 19 46Immediate cause of death fracture, intercostal, left femur 19 days

DURATION

Fracture, intercostal, left femur 19 daysDue to Fall on sidewalk -Diabetes mellitusDue to ArteriosclerosisOther conditions Hypostatic pneumoniaEmphysema

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Headed Date of Aug 16 1946Where did injury occur? Hagerstown Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) on streetMeans of injury Fallen on sidewalk Injured at work?23. SIGNATURE Wm. A. Conway M. D. or otherAddress 5 W. Washington Date signed 9/6/46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 11 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

09385
Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, institution, or street address where death occurred:
2. main St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. N. main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Harry W. Uygand

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Flora M. Uygand
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) February 17, 1871
 8. AGE: Years 75 Months 7 Days 13 It less than one day _____ hrs. _____ min.

8. Birthplace Sharpsburg Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business Own Farm

12. Name Joshua Uygand

13. Birthplace Wash. Co. Md.

14. Maiden name Ann Miller

15. Birthplace Wash. Co. Md.

16. Informant Denver S. Uygand

Address Boonsboro Md.

17. Burial Date thereof Oct. 2, 1946

(Burial, cremation, or removal Which?) _____ (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Chas. J. Bait & Son

Address Boonsboro Md.

19. Oct. 2, 1946 John S. Bait
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1946 at 8:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20, 1946 to Sept. 30, 1946

and that I last saw him alive on Sept. 29, 1946

Immediate cause of death _____

DURATION

10 days

Due to Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hubert Rader, M.D. M. D. or other _____

Address Boonsboro Md. Date signed 10/1/46

RECEIVED
OCT 4 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

336 1/2 N. Jonathan Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 336 1/2 N. Jonathan St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rosie Anna Yates

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18, 1901

8. AGE:

45

Years 7

Months 21

Days It less than one day

hrs. min.

9. Birthplace Rippon W. Va.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

John Yates

13. Birthplace

Rappahannock Co., Va.

14. Maiden name

Emma Nash

15. Birthplace

Rippon W. Va.

16. Informant

Mrs. Dorothy Butler

Address

336 1/2 N. Jonathan St.

17.

(Burial, cremation, or removal. Which?)

Date thereof

9/11/46
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

William H Downey

Address

291 Fredrick St

19.

(Date rec'd by registrar)

Sept. 11, 1946

Bessie Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1946 to Sept. 8th, 1946

and that I last saw her alive on Sept. 6, 1946

Immediate cause of death

Carcinoma - Cervix Uteri

DURATION

10 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. J. Anderson MD

M. D. or other

Address

159 W. Washington St.

Date signed

9/11/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 13 1946
BUREAU V.C.